IAR GEL
CERBATIONS
Pharmaceuticals, Inc., Ellicott City, MD

RESULTS

White Blood Cell Summary

Table 2: Cell Counts and Automated Differential

	IVMP			Acthar			p Values		
	Baseline	Day 3	Day 5	Baseline	Day 3	Day 5	Baseline	Day 3	Day 5
Total WBC (x10³/mm³)	7.22 (1.05)	20.7 (3.46)	15.4 (3.11)	6.81 (1.12)	12.7 (3.89)	12.2 (3.04)	0.20	<0.0001	0.002
% Neutrophils	56.1 (6.83)	85.5 (4.82)	80.8 (6.52)	55.1 (8.30)	70.7 (9.05)	63.3 (8.99)	0.78	<0.0001	<0.0001
% Lymphocytes	31.7 (5.29)	9.08 (3.59)	12.6 (5.06)	31.0 (6.84)	21.4 (7.67)	28.3 (7.97)	0.70	<0.0001	<0.0001

Mean (SD); N=17 for IVMP, N=18 for Acthar; all analyses done at pre-dose each day; statistical analyses comparing IVMP and Acthar cell counts and % were done by the Mann-Whitney test. Flow cytometry data further support these findings (data not shown).

Safety Assessment Summary

- All observed AEs were mild in severity.
- In this healthy subject study, there were more drug-related AEs observed after IVMP administration than with Acthar; however, the number of subjects experiencing AEs with each treatment was not statistically different.
- Although mean blood glucose values did not significantly differ after administration of Acthar as compared to IVMP, the range of blood glucose values was larger following IVMP.
- Effects of Acthar and IVMP on mean arterial pressure (MAP) were similar and relatively small based upon this crossover study in the healthy subject population.

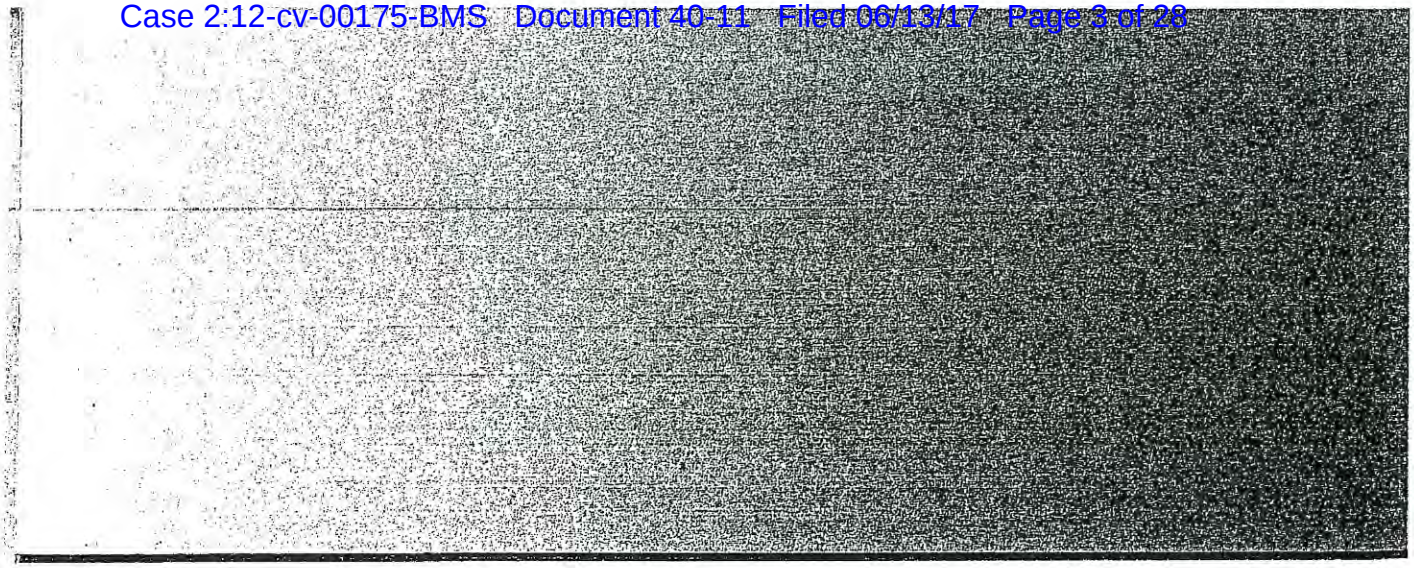
SUMMARY & CONCLUSIONS

- In this study, the total steroid exposure was statistically greater for IVMP than Acthar, demonstrated by serum and PUF cortisol-equivalent exposure ratios (Acthar:IVMP) on Day 5 of 0.04±0.01 and 0.06±0.03, respectively, (p-value of <0.001 in both cases).
- Assuming linearity, 80 U of Acthar would equate to approximately 40–60 mg of IVMP based upon total serum and free plasma steroid (cortisol equivalent) exposure.
- In this healthy subject population, the total WBC increased less following Acthar as compared with IVMP ($p<0.005$). Acthar appeared to cause less lymphopenia and neutrophilia than IVMP, with greater recovery of lymphocyte and neutrophil counts by Day 5.
- Although some differences in the pharmacodynamic outcomes and safety assessments were noted in this healthy subject crossover study (N=18), the extrapolation and relevance to patient population clinical outcomes remains to be investigated.

*All authors are employees of Questcor Pharmaceuticals, Inc.

Important Safety Information

- Acthar should never be administered intravenously.
- Administration of live or live attenuated vaccines is contraindicated in patients receiving immunosuppressive doses of Acthar.
- Acthar is contraindicated where congenital infections are suspected in infants.
- Acthar is contraindicated in patients with scleroderma, osteoporosis, systemic fungal infections, ocular herpes simplex, recent surgery, history of or the presence of a peptic ulcer, congestive heart failure, uncontrolled hypertension, primary adrenocortical insufficiency, adrenocortical hyperfunction or sensitivity to proteins of porcine origin.
- The adverse effects of Acthar are related primarily to its steroidogenic effects.
- Acthar may increase susceptibility to new infection or reactivation of latent infections.
- Suppression of the HPA may occur following prolonged therapy with the potential for adrenal insufficiency after withdrawal of the medication. Cushing's syndrome may occur during therapy but generally resolves after therapy is stopped. Monitor patients for signs and symptoms.
- Monitor patients for elevation of blood pressure, salt and water retention, and hypokalemia.
- Acthar often acts by masking symptoms of other diseases/disorders. Monitor patients carefully during and following discontinuation.
- Acthar can cause GI bleeding and gastric ulcer, with an increased risk for perforation with certain GI disorders. Monitor for signs of bleeding.
- Acthar may be associated with CNS effects ranging from euphoria, insomnia, irritability, mood swings, personality changes, depression, and psychosis. Existing conditions may be aggravated.
- Patients with comorbid disease may have that disease worsened. Caution should be used in patients with diabetes and myasthenia gravis.
- Prolonged use of Acthar may produce cataracts, glaucoma and secondary ocular infections.
- Acthar is immunogenic and prolonged use may increase the risk of hypersensitivity reactions.
- There is an enhanced effect in patients with hypothyroidism and those with cirrhosis of the liver.
- Long-term use may have negative effects on growth and physical development in children. Monitor pediatric patients.



- Decrease in bone density may occur. Monitor during long-term therapy.
- Pregnancy Class C: Acthar has been shown to have an embryocidal effect and should be used during pregnancy only if the potential benefit justifies the potential risk to the fetus.
- Common adverse reactions include fluid retention, alteration in glucose tolerance, elevation in blood pressure, behavioral and mood changes, increased appetite, and weight gain.
- Specific adverse reactions reported in IS clinical trials in infants and children under 2 years of age included: infection, hypertension, irritability, Cushingoid symptoms, constipation, diarrhea, vomiting, pyrexia, weight gain, increased appetite, decreased appetite, nasal congestion, acne, rash, and cardiac hypertrophy. Convulsions were also reported, but these may actually be occurring because some IS patients progress to other forms of seizures and IS sometimes mask other seizures, which become visible once the clinical spasms from IS resolve.

Other adverse events reported are included in the full Prescribing Information.

Please see the accompanying full Prescribing Information for additional Important Safety Information.

QUESTCOR®

H.P. **Acthar**® GEL
(repository corticotropin injection) 80 U/mL

EXHIBIT G

QUESTCOR

FRM-0038; Revision 01
PAGE 1

Questcor Pharmaceuticals, Inc.
3260 Whipple Road
Union City, California 94587
www.questcor.com

Medical Information Request Form (MIRF)
for Health Care Professionals

Product: H.P. Acthar® Gel ☐ Doral® Tablets ☐

Name of Healthcare Professional/Requestor: _____ Date: _____

Healthcare Professional: MD ☐ DO ☐ Pharm D ☐ RN ☐ RPh ☐ NP ☐ PA ☐
Other ☐ (please specify): _____

Healthcare Professional Specialty: _____

Name of Medical Organization: _____

Type of Organization: Clinic ☐ Private Practice ☐ Medical Center ☐ Govt. Medical Facility ☐
Academic Institution ☐ Community/Patient ☐ Association/Foundation ☐
Other ☐ (please specify): _____

Healthcare Professional/Requestor - Mailing Information:

Address: _____

City: _____ State: _____ Zip: _____

Healthcare Professional/Requestor – Contact Information:

Phone No.: _____ Fax No.: _____

Email: _____

Preferred Route of Delivery (check preference(s)): Mail ☐ *Fax ☐ *E-mail ☐

Does this inquiry involve patient(s) who received Questcor product(s)? Yes ☐ No ☐

Inquiry/Literature Request: _____

_____

I acknowledge that I have requested the information described above to be provided to me by Questcor Pharmaceuticals Inc. or a designated agent.

Signature of Healthcare Professional/Requestor: _____

Title: _____

Date: _____

*Copyright limitations may prohibit electronic dissemination; therefore FedEx Overnight will be used in these cases.

Questcor Representative acknowledging unsolicited request:

From: _____

Signature: _____

Please fax this form to the following number: 1-866-405-9677

For any further information regarding your medical inquiry, please contact MI at 1-800-468-9217.

EXHIBIT H

H.P. Acthar GEL
(repository corticotropin injection) 80 U/mL

Acthar Support & Access Program (A.S.A.P.)

Phone: 1-888-435-2284 Fax: 1-877-937-2284

ACTHAR SUPPORT & ACCESS PROGRAM A.S.A.P.

Please submit this referral form and outpatient prescription to initiate Acthar therapy. The Acthar Support & Access Program is available Monday – Friday from 8:00 am – 8:00 pm Eastern Time

Last Name / First Name	Today's Date / Date Needed
Caregiver Name / Relationship / Cell Phone	Prescriber Full Name: Amos Katz, MD / Tax ID#: 611593966
Home Phone Number / Work Phone Number	Hospital/Clinic: Centrastate Medical Center - MS Center / Medicaid / Medicare Provider #
Home Address / City / State / Zip	Prescriber Address: 901 W. Main Street / City: Freehold / State: NJ / Zip: 07728
Shipping Address (if different from home address) ☐ Physician ☐ Home ☐ Other	Primary Office Contact: Michele Emmons / Contact's Direct Phone Number: 732-637-6305
Gender: ☐ Male ☐ Female / Date of Birth:	Back-Up Office Contact: Rita / Contact's Direct Phone Number: 732-294-2505
Language Preference: ☐ English ☐ Spanish ☐ Other	Prescriber Specialty: ☑ Neurology ☐ Nephrology ☐ Rheumatology ☐ Other:
Allergies / Patient Weight	Office Main Phone Number: 732-294-2505 / Office Fax Number:
Special Instructions:	

INSURANCE INFORMATION

(Fill out entirely & fax a copy of patient's insurance card, *both sides*)

☐ Uninsured (Notes:)

Primary Insurance: _____
Policy Holder Name: _____
Policy Holder DOB: _____
Policy #: _____
Group #: _____
Phone #: _____
Rx Drug Card: Name _____ Card # _____

Diagnosis / Prior Authorization Info*

Primary Diagnosis: ☐ Infantile Spasms ☑ Multiple Sclerosis
☐ Nephrotic Syndrome ☐ Dermatomyositis ☐ Polymyositis
☐ Other (Specify) Acute MS Exacerbation
ICD-9 Code (if known): 340
For IS patients only: Has Patient Started Treatment? ☐ Yes ☐ No
If yes, date started: _____ Patient is currently ☐ Inpatient ☐ Outpatient

**ASAP will let you know if the patient's insurer requires a Prior Authorization. Please be prepared to fax applicable chart notes, treatment history, Letter of Medical Necessity, etc if requested for supporting documentation. Fax items to ASAP at 1-877-937-2284*

PRESCRIPTION FORM

(Please PRINT clearly and SIGN below.)

ACTHAR GEL 80 UNITS/ML 5ML MULTI DOSE VIAL

Sig: 80 units once / day for 5 consecutive days

Route of Administration: ☐ IM ☐ SC

Qty: 1 Refills x: 0

Supplies: *Please check and complete all that apply*

☐ 1 cc syringe Quantity: ____ ☐ 23 g needle 1 inch Quantity: ____
☐ 3 cc syringe Quantity: ____ ☐ 25 g needle 1 inch Quantity: ____
☐ 25 g needle 5/8 inch Quantity: ____
☐ Other: _____

Home Injection Training Services (HITS) *For Adult Cases Only*

By initialing here (original required, cannot copy) I request that company-funded HITS services be arranged for my patient. I understand that HITS is for one instruction visit only and NOT a Home Health Nursing Service. I also understand that all reasonable efforts will be made to schedule the HITS training visit within 48 hours of the patient's receipt of drug shipment. Date: _____ Initials: _____

PRESCRIBER CONSENT (Required) I authorize BioSolutia® Pharmaceutical Services LLC (BPS) as the operator of the Acthar Support and Access Program, to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any patients enrolled with the program support center to the insurer of such patients and to obtain any information about such patients, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or health care operation purposes, and from health care providers, such as pharmacies, for treatment purposes, including to track the status of medications dispensed by those pharmacies for my patients for coordination of care and related purposes. BPS may de-identify any and all protected health information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR 164.514(b). As my business associate, BPS is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR §§ 164.308 – 164.312, 164.410, 164.504(e) and the HITECH Act regarding business associates, and that it will safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise required by law. I certify that H.P. Acthar® Gel is medically necessary for this patient and that I have reviewed this therapy with the patient and will be supervising the patient's treatment. I understand that representatives from A.S.A.P. may contact my patient for additional information relating to this referral. I acknowledge and agree that the designated specialty pharmacy receive this prescription via a designated third party, A.S.A.P., and that no additional confirmation of receipt of prescription is required by the designated specialty pharmacy.

PRESCRIBER SIGNATURE REQUIRED TO CONSENT AND VALIDATE PRESCRIPTIONS – Original Signature, No Stamps

Prescriber Signature: _____ Date: _____ NPI#: 1952411340 State License#: 25MA04219600

Rev. 2012.11.27

H.P. Acthar GEL (repository corticotropin injection) 80 U/mL

ACTHAR SUPPORT & ACCESS PROGRAM A.S.A.P.

Acthar Support & Access Program (A.S.A.P.)

Phone: 1-888-435-2284 Fax: 1-877-937-2284

Please submit this referral form and outpatient prescription to initiate Acthar therapy. The Acthar Support & Access Program is available Monday – Friday from 8:00 am – 8:00 pm Eastern Time

Last Name / First Name	Today's Date / Date Needed
Caregiver Name / Relationship / Cell Phone	Prescriber Full Name: Terence McAlarney, MD / Tax ID#: 562440977
Home Phone Number / Work Phone Number	Hospital/Clinic: Centrastate Medical Center - MS Center / Medicaid / Medicare Provider #
Home Address / City / State / Zip	Prescriber Address: 901 W. Main Street / City: Freehold / State: NJ / Zip: 07728
Shipping Address (if different from home address) ☐ Physician ☐ Home ☐ Other	Primary Office Contact: Michele Emmons / Contact's Direct Phone Number: 732-637-6305
Gender: ☐ Male ☐ Female / Date of Birth:	Back-Up Office Contact: Rita / Contact's Direct Phone Number: 732-294-2505
Language Preference: ☐ English ☐ Spanish ☐ Other	Prescriber Specialty: ☑ Neurology ☐ Nephrology ☐ Rheumatology ☐ Other:
Allergies / Patient Weight	Office Main Phone Number: 732-294-2505 / Office Fax Number:
Special Instructions:	

INSURANCE INFORMATION

(Fill out entirely & fax a copy of patient's insurance card, *both sides*)

☐ Uninsured (Notes:)

Primary Insurance: _____

Policy Holder Name: _____

Policy Holder DOB: _____

Policy #: _____

Group #: _____

Phone #: _____

Rx Drug Card: Name _____ Card # _____

Diagnosis / Prior Authorization Info*

Primary Diagnosis: ☐ Infantile Spasms ☑ Multiple Sclerosis ☐ Nephrotic Syndrome ☐ Dermatomyositis ☐ Polymyositis

☑ Other (Specify) Acute MS Exacerbation

ICD-9 Code (if known): 340

For IS patients only: Has Patient Started Treatment? ☐ Yes ☐ No

If yes, date started: _____ Patient is currently ☐ Inpatient ☐ Outpatient

** ASAP will let you know if the patient's insurer requires a Prior Authorization. Please be prepared to fax applicable chart notes, treatment history, Letter of Medical Necessity, etc if requested for supporting documentation. Fax items to ASAP at 1-877-937-2284*

PRESCRIPTION FORM

(Please PRINT clearly and SIGN below.)

ACTHAR GEL 80 UNITS/ML 5ML MULTI DOSE VIAL

Sig: 80 units once / day for 5 consecutive days

Route of Administration: ☐ IM ☑ SC

Qty: _____ Refills x: _____

Supplies: *Please check and complete all that apply*

☐ 1 cc syringe Quantity: ____ ☐ 23 g needle 1 inch Quantity: ____

☑ 3 cc syringe Quantity: 6 ☐ 25 g needle 1 inch Quantity: ____

☑ 25 g needle 5/8 inch Quantity: 6

☐ Other: _____

Home Injection Training Services (HITS) *For Adult Cases Only*

By initialing here (original required, cannot copy) I request that company-funded HITS services be arranged for my patient. I understand that HITS is for one instruction visit only and NOT a Home Health Nursing Service. I also understand that all reasonable efforts will be made to schedule the HITS training visit within 48 hours of the patient's receipt of drug shipment. Date: _____ Initials: _____

PRESCRIBER CONSENT (Required) I authorize BioSolutia® Pharmaceutical Services LLC (BPS) as the operator of the Acthar Support and Access Program, to be my designated agent and to act as my business associate (as defined in 45 CFR 160.103) to use and disclose any information about any patients enrolled with the program support center to the insurer of such patients and to obtain any information about such patients, including any protected health information (as defined in 45 CFR 160.103), from the insurer, including eligibility and other benefit coverage information, for my payment and/or health care operation purposes, and from health care providers, such as pharmacies, for treatment purposes, including to track the status of medications dispensed by those pharmacies for my patients for coordination of care and related purposes. BPS may de-identify any and all protected health information of my patients, provided that the de-identification complies with the requirements set forth in 45 CFR 164.514(b). As my business associate, BPS is required to comply with, and by its signature hereto, agrees that it will comply with, the applicable requirements of 45 CFR §§ 164.308 – 164.312, 164.410, 164.504(e) and the HITECH Act regarding business associates, and that it will safeguard any protected health information that it obtains on my behalf, and will use and disclose this information only for the purposes specified herein or as otherwise required by law. I certify that H.P. Acthar® Gel is medically necessary for this patient and that I have reviewed this therapy with the patient and will be supervising the patient's treatment. I understand that representatives from A.S.A.P. may contact my patient for additional information relating to this referral. I acknowledge and agree that the designated specialty pharmacy receive this prescription via a designated third party, A.S.A.P., and that no additional confirmation of receipt of prescription is required by the designated specialty pharmacy.

PRESCRIBER SIGNATURE REQUIRED TO CONSENT AND VALIDATE PRESCRIPTIONS – Original Signature, No Stamps

Prescriber Signature: _____ Date: _____ NPI#: 1184773707 State License#: 25MA072179

Rev. 2012.11.27

EXHIBIT I

H.P. ACTHAR® GEL
(repository corticotropin injection) 80 U/mL

Please complete Referral Form and fax toll-free
FAX: 1-877-937-2284 TEL: 1-888-435-2284

1. PATIENT INFORMATION

PATIENT FIRST NAME | PATIENT MIDDLE INITIAL | PATIENT LAST NAME | DATE OF BIRTH | GENDER

HOME ADDRESS | CITY | STATE | ZIP

SHIPPING ADDRESS (IF NOT HOME ADDRESS) | CITY | STATE | ZIP

TELEPHONE | ALTERNATE TELEPHONE | BEST TIME TO CALL | PREFERRED LANGUAGE IF NOT ENGLISH

EMAIL ADDRESS | PATIENT REPRESENTATIVE | RELATIONSHIP | TELEPHONE

2. FOR PATIENT REVIEW AND COMPLETION

Acthar Support and Access Program Patient Authorization

By signing this authorization, I authorize my physician(s), my health insurance company, and my pharmacy providers to disclose to Questcor Pharmaceuticals, Inc., the manufacturer of Acthar ("Questcor"), and its agents, authorized designees and contractors, including United BioSource Corporation ("UBC") or any other operator of the Acthar Support and Access Program on behalf of Questcor (collectively, "Designated Parties"), health information relating to my medical condition, treatment, and insurance coverage (my "Health Information") in order for them to provide certain services to me, including reimbursement and coverage support, patient assistance and access programs, medication shipment tracking, and home injection training and also to provide me with other educational and support services associated with Acthar therapy, and for the Acthar Support and Access Program's proper management and administration and for Questcor to carry out its legal responsibilities. (Please see reverse side for full Authorization.)

Patient Authorization and Registration for optional supplemental education and support programs available for patients prescribed Acthar.

Questcor provides ongoing education and support for patients whose healthcare providers have determined that Acthar is the appropriate clinical therapy for their patients. Check the appropriate box(es) and sign below to participate and receive ongoing education and support at no cost to you. Specifically, I authorize Questcor and its agents to receive, use, and disclose my health information relating to my medical condition, treatment, insurance coverage, and contact information from me, my health care providers, and my health insurance company in order to (1) contact me about participation in Acthar patient programs; (2) provide me with educational or information materials; (3) administer its education and support programs appropriately; (4) conduct surveys that request my feedback; and (5) for Questcor to carry out its legal responsibilities. I agree to let Questcor or its agents contact me in the future about these offerings. (Please see reverse side for full Authorization.)

☐ By checking this box and signing below, I confirm understanding of the Patient Authorization for the Acthar Support and Access Program.

☐ By checking this box and signing below, I confirm understanding of the Patient Authorization and Registration for optional supplemental education and support programs available for patients prescribed Acthar.

PATIENT NAME OR LEGAL REPRESENTATIVE | PATIENT SIGNATURE | IF LEGAL REPRESENTATIVE, RELATIONSHIP TO PATIENT | DATE

3. INSURANCE INFORMATION (PLEASE INCLUDE COPIES OF CARDS)

PHARMACY BENEFITS | SUBSCRIBER ID # | GROUP # | TEL #

PRIMARY MEDICAL INSURANCE | POLICY HOLDER / RELATIONSHIP | SUBSCRIBER ID # | GROUP # | TEL #

4. HCP INFORMATION

HCP FIRST NAME | HCP LAST NAME | HCP MIDDLE INITIAL | NPI # | GROUP NPI # (IF APPLICABLE) | STATE LICENSE #

SPECIALTY: ☐ NEPHROLOGY ☐ NEUROLOGY ☐ PULMONOLOGY ☐ RHEUMATOLOGY ☐ OTHER

FACILITY NAME | TELEPHONE | FAX

ADDRESS | CITY | STATE | ZIP

OFFICE CONTACT NAME | CONTACT TELEPHONE | EMAIL ADDRESS | PREFERRED METHOD OF COMMUNICATION

5. PRESCRIPTION: H.P. ACTHAR® GEL NDC 63004-8740-1 5 mL multidose vial containing 80 USP units per mL

DIAGNOSIS:

INITIATE PATIENT WITH:

DOSE: ☐ UNITS ☐ ML SCHEDULE/FREQUENCY: EVERY ____ ☐ HOURS ☐ DAYS ☐ WEEKS FOR ____ ☐ DAYS ☐ WEEKS ☐ MONTHS

ROUTE OF ADMINISTRATION ☐ INTRAMUSCULAR ☐ SUBCUTANEOUS

QUANTITY OF 5 ML MULTIDOSE VIALS: ____ REFILLS: ____

ADDITIONAL SPECIAL INSTRUCTIONS, OR TAPER DOSE, IF APPLICABLE:

SUPPLIES:

SYRINGE SIZE: ☐ 1 cc ☐ 3 cc (other) ____ QUANTITY: ____ NEEDLE SIZE: ☐ 20 g needle, 1 inch ☐ 23 g needle, 1 inch ☐ 25 g needle, 1 inch ☐ 25 g needle, 5/8 inch ☐ (other) ____ QUANTITY: ____

OTHER SUPPLIES: ____ REFILLS: ____

HOME INJECTION TRAINING SERVICES (HITS) FOR ADULT PATIENTS

By initialing here (original required) I request that company-funded HITS services be arranged for my patient. I understand that HITS is for one instruction visit only and NOT a home health nursing service. I also understand that all reasonable efforts will be made to schedule the HITS training visit within 24 hours of the patient's receipt of drug shipment.

INITIALS | DATE

6. PRESCRIPTION, CONSENT, AND STATEMENT OF MEDICAL NECESSITY: HCP SIGNATURE REQUIRED

I certify that H.P. Acthar® Gel is medically necessary for this patient and that I have reviewed this therapy with the patient and will be monitoring the patient's treatment. I verify that the patient and healthcare provider information on this enrollment form is complete and accurate to the best of my knowledge. (Continued on reverse.)

HCP Prescriber Signature - Please sign ONE LINE below

DISPENSE AS WRITTEN | DATE | SUBSTITUTIONS ALLOWED | DATE

Prescriber signature required to consent and validate prescriptions. Prescriber attests that this is her/his signature. NO STAMPS. By signing, I certify that the above is medically necessary.

H.P. Acthar® GEL
(repository corticotropin injection) 80 U/mL

2. FOR PATIENT REVIEW AND COMPLETION (CONTINUED FROM REVERSE)

Acthar Support and Access Program Patient Authorization (Continued from reverse)

Once my Health Information has been disclosed to the Designated Parties, I understand that it may be redisclosed by them as permitted by this authorization or as otherwise permitted or required by law and will no longer be protected by federal and state privacy laws. However, the Designated Parties agree to protect my Health Information by using and disclosing it only for the purposes authorized in this authorization or as permitted or required by law.

I understand that I may refuse to sign this authorization and that my physician and pharmacy will not condition my treatment on my agreement to sign this authorization form, and my health plan or health insurance company will not condition payment for my treatment, insurance enrollment or eligibility for insurance benefits on my agreement to sign this authorization form. I understand that my pharmacies may receive payment in connection with the disclosure of my Health Information as provided in this authorization. I understand that I am entitled to receive a copy of this authorization after I sign it.

I may revoke (withdraw) this authorization at any time by mailing a letter to Acthar Support and Access Program at 25125 Santa Clara St. #E287, Hayward, CA 94544-2109, or by sending an email to ASAP@questcor.com. Revoking this authorization will end further disclosure of my Health Information to Questcor by my pharmacy, physicians and health insurance company when they receive a copy of the revocation, but it will not apply to information they have already disclosed to the Designated Parties based on this authorization. If I revoke or withdraw this authorization, I know that this means I may no longer be able to receive assistance from the Acthar Support and Access Program.

This authorization is in effect for 1 year once I have signed it unless I cancel it before then.

Patient Authorization and Registration for optional supplemental education and support programs available for patients prescribed Acthar (Continued from reverse)

Specifically, I authorize Questcor and its agents to receive, use, and disclose my health information relating to my medical condition, treatment, insurance coverage, and contact information from me, my health care providers, and my health insurance company in order to (1) contact me about participation in Acthar patient programs; (2) provide me with educational or information materials; (3) administer its education and support programs appropriately, (4) conduct surveys that request my feedback and (5) for Questcor to carry out its legal responsibilities. I agree to let Questcor or its agents contact me in the future about these offerings. Once my health information has been disclosed to the education and/or support program I choose to participate in, I understand that it may be re-disclosed by Questcor or its agents, and they are authorized to use or disclose this information in the manner described here and as permitted by this authorization or as otherwise permitted or required by law, and that federal and state privacy laws may no longer protect the information. However, the Questcor and its agents agree to protect my health information by using and disclosing it only for the purposes described in this authorization or as permitted or required by law.

I also know I may cancel my enrollment in a patient support program at any time by contacting Questcor at 25125 Santa Clara St. #E287, Hayward, CA 94544-2109, or by sending an email to ASAP@questcor.com. Cancelling this authorization will end further use or disclosure of my health information by Questcor or its agents (except to the extent that such parties took actions based on this authorization prior to my revocation). If I withdraw my permission, I know that this means I may no longer receive information on supplemental education programs. Once I withdraw my permission, no new information will be disclosed to Questcor or its agents, but Questcor and its agents may continue to use the information that was collected before I withdrew my permission as permitted by this authorization or as otherwise permitted or required by law.

I understand I do not have to sign this form. It plays no role in getting my medicine. It is not part of receiving help from the Acthar Support and Access Program, which is different from the optional ongoing education and support program.

6. PRESCRIPTION, CONSENT AND STATEMENT OF MEDICAL NECESSITY (CONTINUED FROM REVERSE)

I authorize United BioSource Corporation ("UBC"), the current operator of the Acthar Support and Access Program ("Program"), and other designated operators of the Program, to perform a preliminary assessment of benefit verification for this patient and furnish information requested by the patient's insurer that is available on this form. I understand that insurance verification is ultimately the responsibility of the provider and third-party reimbursement is affected by a variety of factors. While UBC tries to provide accurate information, they and Questcor make no representations or warranties as to the accuracy of the information provided.

I understand that representatives from the Program or UBC may contact me or my patient for additional information relating to this prescription. I acknowledge and agree that the designated specialty pharmacy receive this prescription via a designated third party, the Program and that no additional confirmation of receipt of prescription is required by the designated specialty pharmacy.

For Patient:_____ DOB:_____

7. DIAGNOSIS AND MEDICAL INFORMATION

Patient H.P. ACTHAR® Gel Therapy Status

- ☐ Naïve/New
- ☐ On Therapy
- ☐ Restart

Date of most recent treatment:

_____
DD/MM/YYYY

Diagnosis

Please select diagnosis and responses to associated questions

- ☐ Infantile spasms
  - ☐ Has diagnosis been confirmed by EEG? ☐ YES ☐ NO
  - Patient's weight: _____
  - Requested drug delivery date: _____
- ☐ Multiple sclerosis
  - Is Acthar to be used to treat an acute exacerbation? ☐ YES ☐ NO
  - Onset of acute exacerbation Date:_____
- ☐ Proteinuria in nephrotic syndrome
  - Please indicate etiology:
    - ☐ Focal segmental glomerular sclerosis (FSGS)
    - ☐ IgA nephropathy (IgAN)
    - ☐ Lupus nephritis
    - ☐ Membranous nephropathy (MN)
    - ☐ Other: _____
- ☐ Dermatomyositis
- ☐ Optic neuritis
- ☐ Polymyositis
- ☐ Psoriatic arthritis
- ☐ Rheumatoid arthritis
- ☐ Systemic lupus erythematosus
- ☐ Sarcoidosis
- ☐ Other diagnosis _____

8. RELEVANT TREATMENT HISTORY

Therapy Name	Dose	Start Date	Stop Date (if applicable)	Comment

9. HISTORY OF CORTICOSTEROID USE (IF APPLICABLE)

Please check all that apply

A corticosteroid was tried with the following response(s):

- ☐ Patient hypersensitive or allergic
- ☐ Patient intolerant to corticosteroids
- ☐ Corticosteroid use failed, but same response not expected with Acthar
- ☐ Other: _____

OR

A corticosteroid was not tried due to the following response(s):

- ☐ Corticosteroid use is contraindicated for this patient
- ☐ Patient has known intolerance to corticosteroids
- ☐ Intravenous access is not possible for this patient
- ☐ Other: _____

HCP SIGNATURE REQUIRED FOR DOCUMENTATION

NAME SIGNATURE DATE

EXHIBIT J

AMERICAN ACADEMY OF NEUROLOGY®

AAN 65th ANNUAL MEETING ABSTRACT

Media Contacts:
Rachel Seroka, rseroka@aan.com, (612) 928-6129
Angela Babb, APR, ababb@aan.com, (612) 928-6102

EMBARGOED FOR RELEASE UNTIL 4 P.M. ET, SUNDAY, MARCH 10, 2013

Abstract Title: #P04.269 - Pilot study of monthly pulse adrenocorticotropic hormone (ACTH) or methylprednisolone as an add-on therapy to beta-interferons for long-term treatment of multiple sclerosis

Press Release Title: Can Hormone Help Treat Multiple Sclerosis Long-Term?

Objective: This single-center, examiner-blinded pilot study evaluated the efficacy and safety of pulse adrenocorticotropic hormone (ACTH) treatment added to beta-interferon in breakthrough multiple sclerosis (MS) compared with pulse methylprednisolone (MP).

Author(s): Regina Berkovich, MD, PhD; Lilyana Amezcua, MD; Dawood Subhani, MBBS; Steven Cen, PhD

Background: ACTH may have immune-modulating mechanisms beyond steroidogenesis that are relevant to the MS disease course. Although ACTH gel is approved to treat MS relapses, its use as pulse therapy is less known.

Designs/Methods: MS patients receiving ongoing beta-interferon treatment were eligible if they had Expanded Disability Status Scale (EDSS) scores of 3.0-6.5 and ≥1 relapse or new T2 or Gadolinium-enhanced lesion within the previous year. Patients were randomly assigned to open?label ACTH (80 units IM once/day x 3 consecutive days) or MP (1 gram IV x 1 dose) monthly for 12 months, with assessments every 3 months for 15 months. Outcomes included relapse rate (primary), EDSS, MS Functional Composite, and MS Quality of Life.

Results: The study included 23 patients (ACTH: n=12, mean±SD EDSS 4.6±1.5; MP: n=11, mean±SD EDSS 4.6±1.3). Over 15 months, the cumulative number of relapses/patient was 0.08 (95% CI: 0.01-0.54) with ACTH and 0.80 (95% CI: 0.36-1.75) with MP (risk ratio [MP vs ACTH]: 9.56 [95% CI: 1.23-74.6; P=0.03]). The cumulative number of psychiatric episodes/patient was greater with MP (0.55 [95% CI: 0.12-2.6]) than with ACTH (0 episodes; P<0.0001). The urinary tract infection cumulative incidence rate with MP was 0.65/patient and with ACTH was 0.16/patient (P=0.25). Mixed effect modeling showed no difference between groups in trajectory slopes of EDSS over time, but significantly stronger (P=0.03) improvement in Mental Health Inventory for ACTH (slope: 0.95/month [P=0.02]) compared with MP (slope: 0.29/month [P=0.32]).

Conclusions: These data suggest a potential benefit of ACTH pulse therapy in breakthrough MS with more favorable relapse and psychiatric side effect profiles. Further studies, including randomized controlled trials are needed to validate these findings.

EXHIBIT K

ACTHAR

CUSTOMER PROFILE

SPECIALIST Lisa Pratta

Physician Name Taimur Zaman MD

Partners

Address 151 Fries Mill Road

City Turnersville State NJ Zip 08080 Email wont give out

Phone 856-269-4258 Cell wont give out

Best days and times for reps.

M anyday T W TH F

Lunch Appt. Yes x No Other appt. times

Dates of lunch appts: every other month in 2016

Dates of RRM visits:

Dates of MDM visits where appropriate:

Office Network

Receptionist name his recep- Cindy

Nurses none hired

MA's (who process referrals?) Rhonda Cell wont give out

System in place to track referrals with key staff member? Y/N who manages? yes and ma manages-one ma per doc

Prior Authorization Nurse- Key contact for RRM if different than above?

NP's (RX Acthar?) none in practice Cell

PA's (Rx Acthar?)_____non in practice_____Cell_____

Office Mgr_____See Irby_____Cell_____

Other staff_____see Irby_____Cell_____

Use Care PLUS or HUB?
_____HUB and a new physican to Acthar_____

Which MC plans present more challenges in obtaining prior authorizations?
Med D plans, Aetna,HBCBS,Aetna,UHC,Prime Therpeutics_____

_____

PAYER

	Private Insurance	Medicare	Medicaid	Cash
% of patients	50	50		

What are some of the most common plans that your patients are covered by w % of practice? (Might have to get from staff) _____see above_____
What is the paid shipped percentage in this account? ____new to Acthar-learning_____

Physician Volume (monthly)

IVMP Average Monthly Volume:____na_____

ACTHAR:
ACTHAR Advocate Y/N? In what patient types?____new to Acthar_____

ACTHAR monthly volume
Nov_____Dec_____ Jan_____Feb_____ Mar_____ Apr_____ May_____
June_____Jul_____Aug_____ Sept____Oct_____ Nov_____Dec_____

Is the physician an ACTHAR Prescriber? Who writes primarily in the clinic? _____no clinic_____

Profiling Questions

DISEASE - MS

# MS Patients per Month	What are their 1st and 2nd line DMT's?	When do they switch DMT's?
Newly Diagnosed: 2	Depends on the patient	Sub optimal or adverse reaction
Relapse:		

- Total MS patients in Veeva /12
- Relapse 34% of all DMT's

Is The ARMS survey in place? Used with all MS patients?

yes

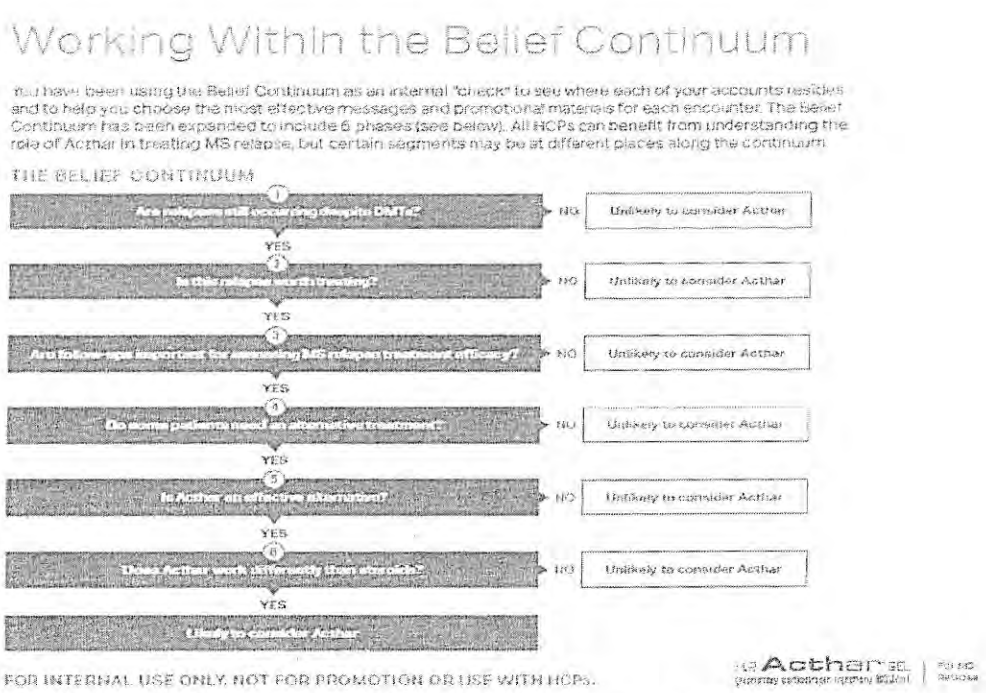
In MS what are the key side effects reported by the infusion suite on IVMP?

na

Disease IS

Infantile Spasm	Comments
What is treatment protocol? 1st line Acthar?	He does not treat IS
Where is the Patient treated? Key staff at Hospital?	

Belief continuum:



Where does this Physician fall on the belief continuum? Why? And next steps? new

How often do they see patients for follow-up? Post relapse in 3 weeks And if relapse free- yearly

Are samples important to the clinic for trial?

Sample dates:

Dates of in services

Clinical Discussions:

Does the physician have a solid understanding of ACTHAR Gels MOA and can explain it (MC receptors, Cortisol levels etc)? new and he is learning

In IS is the proper dose being prescribed of 75Um2 BID?

na

In IS is high dose prednisone being used? If so why and what is the action plan?

In IS does the Physician and staff have the dosing app downloaded and know how to add tapers?

In IS does the Physician use or consider treating with Acthar in patients with TS? If not why not and action plans?

Does the Physician perceive ACTHAR as a Corticosteroid?

no

Does the Physician understand ACTHAR is indicated first line in relapse? Acthar is not indicated as first line therapy in the treatment of MS relapses If second line do they understand it is managed care restriction of ACTHAR ONLY?

yes

Given NO MGD CARE issues, does the physician view ACTHAR as standard of care and first line based on value vs restriction?

na

What are next action plans if answer is no?

Does the Physician understand that MANAGED CARE will likely only approve if a patient meets the plans criteria for use?

yes

What is the treatment protocol in relapse that is preferred?

IVMP

Does the physician use IVIG? yes Why/ When?

Plasmapheresis in use? no Why/When?

IN MS what is the treatment Philosophy relative to treating a relapse? Extremely important? What does follow up with patients look like? post relapse in 3 weeks with a phone call to patient before visit after treatment with ivmp, if patient is healthy they will the the doc yearly

Date **CALL NOTES**

	CALL OBJECTIVES: Based on above
	DATA PRESENTED:

	OBJECTIONS:
	STRATEGIES TO OVERCOME OBJECTIONS:
	NEXT CALL OBJECTIVES:

Date	NOTES

EXHIBIT L

QUESTCOR PHARMACEUTICALS, INC.

MS Speakers Trained on Acthar®

Approved Speakers Name and Affiliation/Office	City	ST	HCP Speaker Programs	Meet-the-Expert	Patient Speaker Programs
Zahid Akram, MD Hermitage Neurology	Hermitage	TN	X		
Timothy Allen, MD Fort Collins Neurology	Fort Collins	CO	X		
Nancy Arndt, RN University of Chicago Medical Center	Chicago	IL	X	X	X
Daniel S. Bandari, MD, MS* MS Center of Southern California	Newport Beach	CA	X		
Ann Bass, MD* Neurology Center of San Antonio	San Antonio	TX	X	X	X
Sudhir Batchu, MD* Columbia Center for Neurology and MS	Columbia	MO	X		
Max Benzaquen, MD Forest Park Hospital	Chesterfield	MO	X		
Regina Berkovich, MD, PhD* University of Chicago Medical Center	Los Angeles	CA	X		
David Brandes, MD* Hope Neurology/MS Center	Knoxville	TN	X	X	X
Staley Brod, MD* University of Texas at Houston	Houston	TX	X	X	X
Steven Bromley, MD Bromley Neurology	Audubon	PA	X		
Janet Brown, MSN, APRN, MSCN* Advanced Neuroscience Institute	Franklin	TN	X	X	X
Marijean Buhse, RN, PhD, NP* State University of NY Stony Brook School of Nursing North Shore University Hospital MS Care Center	East Meadow	NY	X		
Tina Butterfield, RN Jacksonville Neurological Clinic	Jacksonville	FL	X	X	X
Ann Cabot, DO* Upper Valley Neurology Neurosurgery PC MS Clinic of New Hampshire	Lebanon	NH	X		
Jean Bakke Cain, RN* Lehigh Valley Physicians, Lehigh Valley Hospital	Allentown	PA	X		
Gary Clauser, MD* Lehigh Valley Physicians, Lehigh Valley Hospital	Allentown	PA	X		
Vincent DiGiovanni, MD Geisinger Wyoming Valley Medical Center	Wilkes-Barre	PA	X	X	X
Amy Dix, PA College Park Neurology	Overland Park	KS	X	X	X
Colby Doepel, NP* Andrew C. Carlos MS Institute	Atlanta	GA	X	X	X
Connie Easterling, ARNP, MSCN* Neurological Services of Orlando	Orlando	FL	X	X	X

H.P. Acthar GEL
(repository corticotropin injection) 80 U/mL

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Zahid Akram, MD Hermitage Neurology	Hermitage		X		
Timothy Allen, MD Fort Collins Neurology	Fort Collins	CO	X		
Nancy Arndt, RN University of Chicago Medical Center	Chicago	IL	X	X	X
Daniel S. Bandari, MD, MS* MS Center of Southern California	Newport Beach	CA	X		
Ann Bass, MD* Neurology Center of San Antonio	San Antonio		X	X	X
Sudhir Batchu, MD* Columbia Center for Neurology and MS	Columbia	MO	X		
Max Benzaquen, MD Forest Park Hospital	Chesterfield	MO	X		
Regina Berkovich, MD, PhD* University of Chicago Medical Center	Los Angeles	CA	X		
David Brandes, MD* Hope Neurology/MS Center	Knoxville		X	X	X
Staley Brod, MD* University of Texas at Houston	Houston	TX	X	X	X
Steven Bromley, MD Bromley Neurology	Audubon		X		
Janet Brown, MSN, APRN, MSCN* Advanced Neuroscience Institute	Franklin	TN	X	X	X
Marijean Buhse, RN, PhD, NP* State University of NY Stony Brook School of Nursing North Shore University Hospital MS Care Center	East Meadow	NY	X		
Tina Butterfield, RN Jacksonville Neurological Clinic	Jacksonville	FL	X	X	X
Ann Cabot, DO* Upper Valley Neurology Neurosurgery PC MS Clinic of New Hampshire	Lebanon	NH	X		
Jean Baldke Cain, RN* Lehigh Valley Physicians, Lehigh Valley Hospital	Allentown	PA	X		
Gary Clauser, MD* Lehigh Valley Physicians, Lehigh Valley Hospital	Allentown	PA	X		
Vincent DiGiovanni, MD Geisinger Wyoming Valley Medical Center	Wilkes-Barre	PA	X	X	X
Amy Dix, PA College Park Neurology	Overland Park	KS	X	X	X
Colby Doepel, NP* Andrew C. Carlos MS Institute	Atlanta	GA	X	X	X
Connie Easterling, ARNP, MSCN* Neurological Services of Orlando	Orlando		X	X	X

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Approved Speakers Cont'd

Name and Affiliation/Office	City	ST	HCP Speaker Programs	Meet-the-Expert	Patient Speaker Programs
Waden E. Emery III, MD, FAAN Emery Neuroscience Center	Lighthouse Point	FL	X	X	X
Michele Emmons RN, BSN, MSCN* CentraState Medical Center	Freehold	NJ	X	X	X
Mary Filipi, PhD, RN, ARNP* Nebraska Medical Center	Omaha	NE	X	X	X
John Foley, MD* Rocky Mountain Neurological Associates	Salt Lake City	UT	X	X	X
Dennis Garwacki, MD Saint Frances Medical Center University of Illinois School of Medicine	Peoria	IL	X		
Scott L. Gold, MD* Melbourne Internal Medicine Association	Melbourne	FL	X	X	
Jeffrey Groves, MD Central Utah Clinic	Provo	UT	X	X	X
Ruwani D. P. Gunawardane, MD Maryland Neurological Center	Columbia	MD	X		
Lori Guyton, MD Neurology of Southern Illinois, Ltd.	Herrin	IL	X		
Lee J. Harris, MD Abington Memorial Hospital	Abington	PA	X	X	X
Barry A. Hendin, MD Banner Good Samaritan Hospital	Phoenix	AZ	X		
Kay A. Hilkey, RN, MSCN* Fort Wayne Neurological Center MS Institute	Fort Wayne	IN	X	X	X
Nicole Hughes, RN, MSN, CNP University of Minnesota Physicians	Minneapolis	MN	X	X	X
Adil Javed, MD, PhD* University of Chicago Hospitals	Chicago	IL	X		
Daniel Kantor, MD Neurologique	Ponte Vedra	FL	X		
Lance Kim, DO Ocala Regional Medical Center Munroe Regional Medical Center	Ocala	FL	X	X	X
Robert L. Knobler, MD Knobler Institute of Neurologic Disease	Fort Washington	PA	X		
Theresa LaRocca, RN, BSN, MSCN* Linda Morgante MS Care Center at Maimonides Medical Center	Brooklyn	NY	X		
William Leuchter, MD Sinai-Grace Hospital	Detroit	MI	X	X	X
K. Alvin Lloyd, MD Riverside Hampton Roads Neurology	Newport News	VA	X		
Brenda Watkins Maas, RN Neurology Center of San Antonio	San Antonio	TX	X		X
Bennett Irving Machanic, MD, FAAN Private Practice	Denver	CO	X	X	X

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Waden E. Emery III, MD, FAAN Emery Neuroscience Center	Lighthouse Point	FL	X		
Michele Emmons RN, BSN, MSCN* CentraState Medical Center	Freehold	NJ	X	X	X
Mary Filipi, PhD, RN, ARNP* Nebraska Medical Center	Omaha	NE	X	X	X
John Foley, MD* Rocky Mountain Neurological Associates	Salt Lake City	UT	X	X	X
Dennis Garwacki, MD Saint Frances Medical Center University of Illinois School of Medicine	Peoria	IL	X		
Scott L. Gold, MD* Melbourne Internal Medicine Association	Melbourne	FL	X	X	
Jeffrey Groves, MD Central Utah Clinic	Provo	UT	X	X	X
Ruwani D. P. Gunawardane, MD Maryland Neurological Center	Columbia	MD	X		
Lori Guyton, MD Neurology of Southern Illinois, Ltd.	Herrin	IL	X		
Lee J. Harris, MD Abington Memorial Hospital	Abington	PA	X	X	X
Barry A. Hendin, MD Banner Good Samaritan Hospital	Phoenix	AZ	X		
Kay A. Hilkey, RN, MSCN* Fort Wayne Neurological Center MS Institute	Fort Wayne	IN	X	X	X
Nicole Hughes, RN, MSN, CNP University of Minnesota Physicians	Minneapolis	MN	X	X	X
Adil Javed, MD, PhD* University of Chicago Hospitals	Chicago	IL	X		
Daniel Kantor, MD Neurologique	Ponte Vedra	FL	X		
Lance Kim, DO Ocala Regional Medical Center Munroe Regional Medical Center	Ocala	FL	X	X	X
Robert L. Knobler, MD Knobler Institute of Neurologic Disease	Fort Washington	PA	X		
Theresa LaRocca, RN, BSN, MSCN* Linda Morgante MS Care Center at Maimonides Medical Center	Brooklyn	NY	X		
William Leuchter, MD Sinai-Grace Hospital	Detroit	MI	X	X	X
K. Alvin Lloyd, MD Riverside Hampton Roads Neurology	Newport News	VA	X		
Brenda Watkins Maas, RN Neurology Center of San Antonio	San Antonio	TX	X		X
Bennett Irving Machanic, MD, FAAN Private Practice	Denver	CO	X	X	X

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Valerie Masotti, PA Mid-Atlantic Neurology & Sleep Medicine	Wilmington	NC	X		
Michael Mazowiecki, MD Neurological Institute of Western Pennsylvania	Greensburg	PA	X	X	X
Maria Melanson, MD* Waddell Center for Multiple Sclerosis University of Cincinnati	Cincinnati	OH	X	X	
Elliot M. Michel, MD Valley Neurology, Inc.	Tarentum	PA	X		
Tamara Ann Miller, MD Advanced Neurology of Colorado	Fort Collins	CO	X	X	
Harold Moses, Jr. MD* Vanderbilt Stallworth Rehab Hospital	Nashville	TN	X		
Shanan Munoz, MD Plano Neurology	Plano	TX	X	X	X
Salvatore Napoli, MD* Caritas Foxboro and Norwood Hospital	Foxboro	MA	X	X	X
Amy Neal, PA* Mandell Center of Multiple Sclerosis Mt. Sinai Rehabilitation Hospital	Hartford	CT	X	X	
Donald Negroski, MD* Medical College of Ohio	Sarasota	FL	X		
Sangjin Oh, MD Private Practice	Glen Burnie	MD	X	X	X
Sean Christopher Orr, MD Baptist Neurology	Jacksonville	FL	X		
Tommasina Papa-Rugino, MD Monmouth Ocean Neurology	Toms River	NJ	X		
Dhruv R. Patel, MD Neurology Center	Elyria	OH	X		
Allan Brian Perel, MD* Richmond University Medical Center Alpha Neurology	Staten Island	NY	X	X	X
Amy Perrin Ross, APN, MSN, CNRN, MSCN* Loyola University of Chicago MS Clinic	Oakbrook	IL	X	X	X
Dottie Pfohl, RN, BS, MSCN* University of Pennsylvania Medical Center	Philadelphia	PA	X		
Mary Ann Picone, MD* Holy Name Hospital	Teaneck	NJ	X	X	X
Colby Powell, PA Private Practice	Pottsville	PA	X		
Clifford Reed, MD Reading Hospital & Medical Center	Reading	PA	X	X	X

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Maria Melanson, MD* Waddell Center for Multiple Sclerosis University of Cincinnati	Cincinnati	OH	X	X	
Elliot M. Michel, MD Valley Neurology, Inc.	Tarentum	PA	X		
Tamara Ann Miller, MD Advanced Neurology of Colorado	Fort Collins	CO	X	X	
Harold Moses, Jr. MD* Vanderbilt Stallworth Rehab Hospital	Nashville	TN	X		
Shanan Munoz, MD Plano Neurology	Plano	TX	X	X	X
Salvatore Napoli, MD* Caritas Foxboro and Norwood Hospital	Foxboro	MA	X	X	X
Amy Neal, PA* Mandell Center of Multiple Sclerosis Mt. Sinai Rehabilitation Hospital	Harford	CT	X	X	
Donald Negroski, MD* Medical College of Ohio	Sarasota	FL	X		
Sangjin Oh, MD Private Practice	Glen Burnie	MD	X	X	X
Sean Christopher Orr, MD Baptist Neurology	Jacksonville	FL	X		
Tommasina Papa-Rugino, MD Monmouth Ocean Neurology	Toms River	NJ	X		
Dhruv R. Patel, MD Neurology Center	Elyria	OH	X		
Allan Brian Perel, MD* Richmond University Medical Center Alpha Neurology	Staten Island	NY	X	X	X
Amy Perrin Ross, APN, MSN, CNRN, MSCN* Loyola University of Chicago MS Clinic	Oakbrook	IL	X	X	X
Dottie Pfohl, RN, BS, MSCN* University of Pennsylvania Medical Center	Philadelphia	PA	X		
Mary Ann Picone, MD* Holy Name Hospital	Teaneck	NJ	X	X	X
Colby Powell, PA Private Practice	Pottsville	PA	X		
Clifford Reed, MD Reading Hospital & Medical Center	Reading	PA	X	X	X

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